The Medicare Part D Prescription Coverage and Limited Income Subsidy Programs - 2008

The Medicare Part D Voluntary Prescription Drug Benefit

One of the biggest concerns for people with Medicare is paying out of pocket for prescription medications. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established a voluntary prescription drug benefit for people with Medicare called Medicare Part D. Medicare Part D began on January 1, 2006.

Who is Eligible for Medicare Part D?

In order to be eligible for Medicare Part D, an individual must:

- Be entitled to Medicare Part A (hospital insurance), and/or enrolled in Medicare Part B (medical insurance),
- Reside in a prescription plan service area, and
- Enroll in a Medicare prescription drug plan.

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Standard Coverage

Most people with Medicare will have to pay a share of their prescription drug costs – others (including AHCCCS recipients and people in our Medicare Cost Sharing Programs) qualify for the Limited Income Subsidy (LIS) program that pays a part or all of the cost sharing. We will cover the LIS program in detail later in this guide.

Here is how the basic prescription coverage works for those who are eligible for standard coverage:

- ⇨ $18.27 average monthly Part D premium.
- ⇨ $275 annual deductible for those who are not eligible for the Limited Income Subsidy (LIS).
- ⇨ $56 annual deductible for those who are not income eligible for Medicaid or Medicare Cost Sharing but who are eligible for Limited Income Subsidy because their income is less than 150% of the FPL.
- ⇨ Once the deductible is met, the person pays 25% of prescription costs (Part D pays 75%) until the annual prescription costs exceed $2,510.
- ⇨ The person pays 100% of prescription costs between $2,510 and $5,726.25 (called the "coverage gap" or "donut hole").
- ⇨ Once the individual's Part D costs exceed $5,726.25, co-pays are $2/$5 or 5% of the price of the prescription, whichever is higher. This is referred to as catastrophic coverage.

How is Medicare Part D Prescription Coverage Provided?

People with Medicare need to select and enroll with a prescription drug plan to receive the Medicare Part D prescription coverage.

Prescription Drug Plan (PDP)

One type of plan is a Prescription Drug Plan (PDP). A PDP covers the entire state of Arizona and cannot be a government agency. The PDP is like a HMO, except the services are limited to prescription drugs.

Medicare Advantage Plans (MA-PD)

As of January 2006, Medicare Plus or Choice plans are called Medicare Advantage (MA) plans (we sometimes refer to this as Medicare replacement). MA plans are required to provide Part D prescription drug coverage. A Medicare Advantage Prescription Drug plan is called an MA-PD.

Special Needs Plan (SNP)

Special Needs Plans are available to individuals with dual-eligibility (people with Medicare and AHCCCS and enrolled with an AHCCCS health plan). There are a few other SNPs in Arizona that offer Medicare to people in nursing facilities.

Approximately 50% of dual eligible customers are enrolled with AHCCCS health plans. Individuals enrolled in an AHCCCS Health Plan may get their Medicaid, Medicare and Part D prescription drug services all from the same health plan.

How is Medicare Part D Prescription Coverage Provided, continued

Employer Plans for Retirees

Medicare continues to work with employers to help keep the coverage people with Medicare have through a current or former employer. Employers receive incentives to continue providing retiree group coverage.

Requirements for Prescription Drug Plans

The following guidelines apply to the Part D plans:

- Must offer a minimum, contracted standard benefit.
- MA-PDs and SNPs may choose to offer enhanced benefits, sometimes for a higher monthly premium.
- The plan decides which drugs are covered, called their formulary.

Coverage Area

Each plan has specific service areas based on the type of plan:

- Prescription Drug Plans provide Part D services to the entire state of Arizona. People with regular Medicare have at least two PDPs to choose from.
- Medicare Advantage Prescription Drug plans provide Part D services to the people with Medicare who enroll with them in their contracted service area.
- Special Needs Plans provide Part D services only to AHCCCS members and other people with Medicare who reside in a nursing facility.

Information About The Prescription Drug Plans Formulary

The list of drugs covered by a plan is called a formulary. CMS requires a plan to have a formulary that contains at least 2 medications, one generic and one brand name, in each of the **146** drug classifications. CMS requires more than 2 medications in some classes of drugs. The Prescription Drug Plans formularies are available to assist beneficiaries when deciding which plan to select. **This is important:** Not all medications are covered by all Medicare drug plans. This is a very important consideration when selecting a plan.

What's Not Covered by Medicare Part D?

Some drugs are excluded from coverage by Medicare drug plans. These include drugs for anorexia, weight loss or weight gain, fertility, cosmetic purposes or hair growth, symptomatic relief of cough and cold, prescription vitamins and mineral products (except pre-natal vitamins and fluoride preparations), non-prescription drugs, and barbiturates and benzodiazepines. If medically necessary, the Medicare prescription drug plan or AHCCCS health plans may cover some of these excluded drugs.

Each plan has a process for handling requests for exceptions to their formulary when a medically necessary drug is not included on the formulary for the plan the individual has selected.

Drug Plan Formulary Exception and Appeal Process

Medicare Part D recipients have several options if a medication is denied by the Medicare drug plan:

1. Request an exception
2. Request a redetermination
3. Appeal

Enrollment

The Annual Coordinated Election Period (AEP) is like our annual enrollment period. People with Medicare can enroll or change plans at this time. The AEP runs from November 15 to December 31 of each year.

For those who become eligible for Medicare, the Initial Enrollment Period is 7 months (begins 3 months before the month of Medicare eligibility, and extends 3 month after the month of eligibility). This is similar to the initial enrollment period for Medicare Part B.

A Special Enrollment Period applies when exceptional circumstances occur including:

- Permanent move out of the plan service area
- Involuntary loss of creditable coverage
- An individual enters or leaves a long term care facility:

Note: Generally, long term care facilities contract with one long term care pharmacy to supply the prescription drugs needed by the residents. CMS strongly encourages the LTC pharmacies to join the network of all prescription drug plans in their areas so people won't have to change prescription drug plans should they need long term care services. However, entering and leaving a long term care facility has been identified as an event when a person can change plans if they need to.

What Happens if the Individual Postpones Enrollment?

In most cases it is in the individual's best interest to enroll as soon as they are eligible. We will talk about an exception in the case of "creditable coverage" below.

Remember this program is voluntary, and an individual can choose NOT to enroll in a Medicare drug plan. But if that individual chooses to enroll later, the premium will increase 1% for each month the customer could have enrolled, but didn't – unless he/she has "creditable coverage".

What is Creditable Coverage?

An individual is considered to have creditable coverage when he/she has health insurance that provides as much or more prescription coverage than the Medicare Part D standard coverage. Some examples of people who have creditable coverage may include group health plans (including employer plans for retirees), those eligible to receive prescriptions from the Veteran's Administration (VA), or military medical coverage through TRICARE. Many people think IHS offers creditable prescription coverage, but CMS has not confirmed this.

When an individual has creditable coverage, there is no penalty assessed for not enrolling in a Medicare drug plan when eligible. An individual with creditable coverage should receive a notice from the source of the current drug coverage indicating whether or not it is creditable coverage.

In other words, if the individual already has prescription coverage that meets or exceeds the standards established for Medicare PDP's he/she will not be penalized for using the other coverage instead of Medicare Part D.

How Do People with Medicare Know About Medicare Part D?

CMS and the Social Security Administration (SSA) conduct outreach throughout the country. CMS also has published information on their web site at www.medicare.gov, and they have expanded their phone bank to answer calls at 1-800-Medicare (1-800-633-4227).

In addition, both Part D and the Limited Income Subsidy are described in the "Medicare and You" hand book that CMS issues each October.

In addition, SSA meets with and trains community groups who can provide assistance to people with Medicare who may need help understanding how Medicare Part D works.

Although CMS is responsible for marketing, notification and assistance for Medicare Part D, you may receive calls from customers asking for clarification or additional information.

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How Does The MMA Affect AHCCCS Recipients?

On January 1, 2006, AHCCCS lost federal funding to provide prescription coverage for people with Medicare. This meant that beginning in January 2006, people with Medicare on AHCCCS must receive prescription coverage through Medicare Part D – not AHCCCS. If an AHCCCS dual eligible does not enroll in Part D (or disenrolls if they are automatically enrolled) they cannot obtain drug coverage from through AHCCCS.

This does not mean, however, that AHCCCS will no longer have to pay for part of these prescription expenses. All state Medicaid agencies will continue to pay CMS for a percentage of the anticipated prescription costs for the dual eligibles phased down over the next 10 years. This is called "clawback".

The following pages will focus on how Part D Medicare works for people with Medicare who receive AHCCCS Medical Services or Medicare Cost Sharing.

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The Limited Income Subsidy (LIS) Program

As part of the Medicare Modernization Act, the Federal government created the Limited Income Subsidy program (LIS – also known as the Extra Help program) to help people with Medicare with their prescription drug costs.

LIS is designed to provide assistance to certain people with Medicare who have limited income and resources. Eligible people will receive full or partial assistance with Part D premiums, deductible and co-pays for prescription drugs.

Note: This is a federal program, and the full or partial assistance provided to eligible people with Medicare is paid for by CMS. *AHCCCS does not pay for any of the cost of these benefits* – there is no state "buy-in" for Medicare Part D like there is for Medicare Parts A and B.

There are three groups of people who fall into the LIS category:

- Dual Eligibles – these are individuals that receive both AHCCCS and Medicare benefits. These customers will automatically be eligible for the LIS.
- Deemed Eligibles – These are individuals that receive QMB only, SLMB or QI-1. In Arizona we call these programs Medicare Cost Sharing, but they are also referred to as Medicare Savings Programs. These customers will also be automatically eligible for the LIS.
- Other individuals whose income is more than 135% of the FPL but less than 150% of the FPL with limited resources.

Dual Eligibles

Dual eligibles are people who are eligible for both Medicare and AHCCCS.

This group includes all customers who have Medicare and also receive AHCCCS Health Insurance (ALTCS, SSI-MAO, AHCCCS for Families and Children (through DES), AHCCCS Freedom to Work and any QMB/Dual).

How Does CMS Know Which Customers Have Medicare And Medicaid?

AHCCCS sends a file to CMS each month that lists all approved customers that have Medicare. The file includes information that ACE transmitted to PMMIS at the time of approval. This is another good reason to make sure all personal, demographic and Medicare information is keyed into ACE correctly.

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How Does Medicare Part D Work for Dual Eligible Customers?

- **No Medicare Part D monthly premium** unless the customer enrolls in a prescription drug plan that requires a premium above the standard amount. In that situation, the customer is responsible to pay the difference.
- **No annual deductible.**
- **No coverage gap.**
- **Maximum co-pays based on income.**
  - $1.05 for generic, $3.10 for brand name if income is ≤ to 100% FPL
  - $2.25 for generic, $5.60 for brand name if income is > 100% FPL
- **No Co-Pays once the total prescription costs reach the catastrophic limit of $5,600**
- **No co-pays for people in a medical institution**

Savings Comparison of Out-Of-Pocket Costs		
Part D Expense	**Standard Part D***	**LIS Dual Eligibles**
Premium	$18.27 (monthly average)	$0
Annual Deductible	$275	$0
Prescription Co-Pay	25% when prescriptions costs are $275 - $2,510 (maximum $500)	Maximum of $1.05/$3.10 if income≤ 100% FPL OR Maximum of $2.25/$5.60 if income > 100% FPL
	100% when prescription costs are $2,510 - $5,726.25 ($3,090)	
	$2/$5 or 5% when prescription costs exceed $5,726.25 (catastrophic coverage)	

*Out of pocket costs for Standard Part D totals $4,050 before catastrophic coverage applies.

Enrollment for Dual Eligibles

Individuals who become a dual eligible can enroll themselves with a Part D drug plan. If they do not enroll themselves in a plan, CMS will enroll them with an MA-PD, a SNP or a PDP that has a premium less than the subsidy amount.

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How Can New Dual Eligibles Prepare For Changes In Prescription Drug Coverage?

If the individual happens to have other health insurance that covers prescriptions, he/she should have received a notice from the health insurance carrier about whether his/her current prescription benefits are considered creditable coverage. If not, he/she can contact the other insurance carrier to find out if the coverage is comparable to Medicare Part D. The Federal government has notified health insurance companies that many of their customers will be requesting this information. The customer should not have problems getting this information.

Once a Prescription Drug Plan is selected, the customer will receive additional information about how the plans work and which medications are covered by each plan.

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Who Are Deemed Eligibles?

Deemed eligibles are people who are eligible for Medicare and are also enrolled in a Medicare Cost Sharing Program.

This group includes all customers who have Medicare and also receive QMB only, SLMB, or QI.

How Does CMS Know Which Customers are Receiving Medicare Cost Sharing?

AHCCCS includes the deemed eligibles, along with the dual eligibles, when sending the monthly file to CMS.

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How Does Medicare Part D Work for Deemed Eligible Customers?

- **No Medicare Part D monthly premium** unless the customer enrolls in a prescription drug plan that requires a premium above the standard amount. If this occurs, the customer is responsible to pay the difference.
- **No annual deductible.**
- **No coverage gap.**
- **Maximum Co-Pays based on income.**
  - $1.05 for generic, $3.10 for brand name if income is ≤ to 100% FPL
  - $2.25 for generic, $5.60 for brand name if income is > 100% FPL
- **No Co-Pays once the total prescription costs reach the catastrophic limit of $5,726.25**

Savings Comparison of Out-Of-Pocket Costs		
Part D Expense	**Standard Part D***	**LIS Deemed Eligibles**
Premium	$18.27 (monthly average)	$0
Annual Deductible	$275	$0
Prescription Co-Pay	25% when prescriptions costs are $275 - $2,510 (maximum $500)	Maximum of $1.05/$3.10 if income ≤ 100% FPL OR Maximum of $2.25/$5.60 if income > 100% FPL
	100% when prescription costs are $2,510 - $5,726.25	
	$2/$5 or 5% when prescription costs exceed $5,726.25 (catastrophic coverage)	

*Out of pocket costs for Standard Part D totals $4,050.00 before catastrophic coverage applies.

Enrollment For Deemed Eligibles:

Deemed eligibles can enroll in a Part D plan on his/her own. If the individual does not,
CMS will enroll them with an MA-PD, a SNP or a PDP that has a premium less than the subsidy amount.

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People Who Get "Extra Help"

People who have income between 135% of the FPL and 150% of the FPL and are not eligible for AHCCCS Health Insurance, QMB, SLMB or QI-1 may qualify for a limited income subsidy. However, they have to apply for this help with the Social Security Administration or AHCCCS.

What Is the Part D Subsidy for Others with Limited Income and Resources?

The subsidy is based on income and resource levels determined by SSA.

The premiums are based on a sliding scale, and the deductibles and co-pays are based on the level of income and resources.

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Social Security Outreach

SSA continues working to identify people with Medicare (excluding those persons already receiving AHCCCS or Medicare Cost Sharing) who may be eligible for the Limited Income Subsidy (LIS) Program, and sends out applications directly to those individuals.

SSA also trains state and local agencies and community organizations to help people with Medicare understand and apply for the Medicare Limited Income Subsidy.

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How Do Customers Apply For This "Extra Help"?

Annually, the Social Security Administration (SSA) mails applications with postage paid return envelopes to people with Medicare who may be eligible for extra help to help pay for Medicare prescription drug costs.

Warning: These are scannable applications that must be completed using black ink or a #2 pencil, and the numbers, letters and Xs must be inside the boxes. **Do not date-stamp a scannable application—write the date in the box marked "For Official Use Only using MM/DD/YYYY format.**

The completed paper application should be mailed to:

Social Security Administration
Wilkes Barre Data Operations Center
P O Box 1020
Wilkes Barre, PA 18767-9910

Or, the application may be completed on-line at www.socialsecurity.gov.

Customers can also apply by telephone with a Social Security Representative by calling 1-800-772-1213.

Who Can Help Complete an Application?

In addition to the applicant himself, there are several individuals who can help the person with Medicare complete the application, these individuals include:

- A personal representative,
- A spouse,
- An adult child,
- A caregiver,
- Advocacy groups,
- A friend,
- Employees or volunteers with the local State Health Insurance Program (SHIP)
- State employees

The Application Process

Verification

Once the application has been submitted, the Social Security Administration uses the following means to obtain verification.

- Client statement
- The use of data matches (e.g., IRS, RR, County Recorder)
- Limited follow up with the customer

How Does Eligibility Work?

There are income and resource limits for the LIS program. The income and resources of the applicant and spouse, if married and living together, are counted in the determination.

The Application Process, continued

Income

Income - The monthly **net** countable income of the applicant and spouse is compared to the **family size** standard to determine if the applicant is within the income limit of 150% of the FPL. Other relatives living in the home are included in determining the family size standard although there income is not counted.

Resources

The resource limit for the LIS has two levels – the level determines the amount of the deductible and co-payments.

- The lower level resource limit is $6,290.00 for an individual or $9,440.00 for a couple.
- The higher resource limit is $10,490 for an individual or $20,970 for a couple.

Refer to the "Benefits and Costs" chart to see how these limits affect the deductible and co-payments.

The Social Security Administration will notify the LIS eligible person of their eligibility for the subsidy and the amount of help they will receive.

Enrollment

Once SSA determines that an individual is eligible for the LIS program, he/she will need to enroll in a prescription drug plan.

A LIS eligible person who does not select a prescription plan will be auto-enrolled in a plan by CMS.

What Are The Advantages of Applying For "Extra Help" With The SSA Rather Than With AHCCCS?

Apply with SSA	Apply with AHCCCS
The SSA is ready to process these applications. They have: • Have staff who can handle applications by phone at 1-800-772-1213 or through the Internet. • Created a scannable application and an on-line application to handle the volume and make it easy for people to apply.	The application process with AHCCCS is a centralized, manual process. • Applicants need to complete a hard copy application. Phone or Internet applications are not available. • There is no automated system to determine this eligibility. Manual worksheets will be used for the income and resource calculations.
No verification has to be submitted with the application. SSA uses automated data matches to verify income and resources.	Verification of income and resources is required.
Guaranteed annual enrollment The SSA does not discontinue anyone who becomes ineligible until December 31st.	**No guaranteed annual enrollment** AHCCCS discontinues eligibility, as changes become known, following our adverse action deadlines.
Streamlined renewal process The SSA sends a form out to customers at time of renewal asking them to respond only if their situation has changed.	AHCCCS uses the normal redetermination process.

What Are The Advantages of Applying For "Extra Help" With The SSA Rather Than With AHCCCS?, continued

In addition to hiring more staff, SSA trains the SHIPs to help people complete the SSA application for LIS and together they hold outreach events where they help people complete the SSA applications.

Encourage people with income low enough for the Medicare Cost Sharing programs to apply with AHCCCS.

Otherwise, encourage an individual with income between 135% of the FPL and 150% of the FPL to apply for the Low Income Subsidy with SSA and help him/her complete either the paper application or the on-line application when they ask for your help.

However, if for some reason the person refuses to have the Social Security Administration process the application, staff in the ALTCS offices and the SSI MAO office will refer the person to the Field Operations Administration in Office for processing.

LIS Determinations Made By AHCCCS

There is no change in how eligibility is determined for our existing programs. There is automatic LIS eligibility for dual eligibles, those who receive Medicare and Medicaid, and deemed eligibles, those who participate in one of our Medicare Cost Sharing Programs.

Your Role in the Medicare Modernization Act and Limited Income Subsidy program:

1. Be prepared to answer questions from AHCCCS customers and the general public.
2. Screen customers for the Medicare Cost Sharing programs and either take their application or refer them to the SSI-MAO or ALTCS offices.
3. Help other customers apply for benefits with SSA.
4. Advise persons who have income between 135% of the FPL and 150% of the FPL to apply with the Social Security Administration for LIS.
5. Direct customers who have questions about enrollment with a prescription drug plan to other available sources for information and help.

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